

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1302

07975

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County

Charles Point

City or town

(If outside city or town limits, write KURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Bastain

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Elizabeth Bastain

7. Birth date of

deceased (mo., day, yr.)

Oct 11 1871

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
74 10 10 hrs. min.

9. Birthplace

Charles Co. Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Tobacco

FATHER

12. Name

Tobacco

MOTHER

13. Birthplace

Charles Co. Md.

14. Maiden name

Maud

MOTHER

15. Birthplace

Charles Co. Md.

16. Informant

Oles Carpenter

Address

Maryland Point, Md.

17.

Burial Date thereof Aug 23 46

(Burial, cremation, or removal. Which?)

(month day) (year)

Cemetery or crematory

Old Burial

Location

Towson, Md.

18. Funeral director

Hunt & Ryer

Address

Waldorf Md.

19. Aug 21 1946

(Date rec'd by registrar)

Maryland Point

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Maryland Point

(If outside city or town limits, write KURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21, 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930 to Aug 21, 1946

and that I last saw him alive on Aug 21, 1946

Immediate cause of death

Chr. Cardio-renal
disease

DURATION

Due to

Chr. Prostatism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

AUG 23 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 300

07976

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Benedict

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Hamilton Bond

4. Sex: male 5. Color or race: white 6. (a) Single, married, widowed, or divorced

7. (b) Name of husband or wife: Margaret H. Bond

8. Birth date of deceased (mo., day, yr.) 2/15/1880 6. (c) If alive, give age years

8. AGE: Years: 66 Months: 6 Days: 14 If less than one day: hrs: min:

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Railroad worker

11. Industry or business

12. Name: unknown

13. Birthplace

14. Maiden name: Alice Bond

15. Birthplace: St. Marys Co. Maryland

16. Informant: Charles E. Hayes

Address: Benedict MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-21-76

Cemetery or crematory: St. Marys

Location: Bayantown 3rd

18. Funeral director: Elmer M. Quade

Address: Keyserville 3rd

19. 8-20 1976 (Date rec'd by registrar) Julia H. Pasey (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Benedict MD

(If outside city or town limits, write RURAL and give nearest town)

Street No: 9 (If rural, give LOCATION)

2.(a) If veteran, name war: A

3. (b) Social Security Number

9

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19th 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1st 1946 to August 19 1946

and that I last saw him alive on August 19 1946

Immediate cause of death:

Syphilis, Cerebrospinal

DURATION

5 years

Due to:

Due to:

Other conditions: Gunma of left lung

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

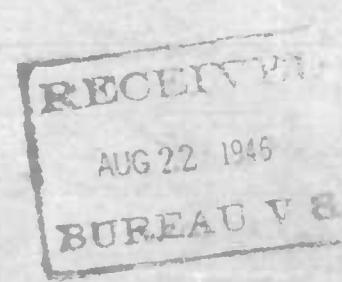
Means of injury

Injured at work?

23. SIGNATURE: Louis G. Hayes M.D.

M. D. or other

Address: Hugherville, Md Date signed: 8-19-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 37a

07977

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles

City or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 3 days

3. (a) FULL NAME

Frances Rebecca Brown

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 10, 1945

6. (c) If alive, give age

years

8. AGE:

Years	Months	Days	If less than one day
9	9		hrs. min.

9. Birthplace

Mt. Victoria, Charles, Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

Frederick Brown

MOTHER FATHER

12. Name

Frederick Brown

13. Birthplace

Charles Co., Md.

14. Maiden name

Frances Rebecca Henley

15. Birthplace

Charles Co., Md.

16. Informant

Frederick Brown

Address

Mt. Victoria, Md.

17. Burial

Catholic Cemetery

(Burial, cremation, or removal. Which?)

Date thereof 8-20-46
(month) (day) (year)

Cemetery or crematory

Catholic Cemetery

Location

Laurel, Md.

18. Funeral director

Fred Brown (Laurel)

Address

Mt. Victoria, Md.

19. 8-20-46

19. (Date rec'd by registrar) 19.

(Date rec'd by registrar)

Julia H. Paetz
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Charles

City or town

Mt. Victoria

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 19, 1946, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 16, 1946, to Aug. 19, 1946
and that I last saw her alive on Aug. 19, 1946

Immediate cause of death

Acute infectious encephalitis

Due to

(Type undetermined, apparently equine)

Due to

DURATION

4 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

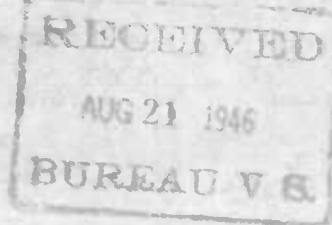
John L. Mackay, M.D.

M. D. or other

Address

La Plata, Md.

Date signed 8-20-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

07978

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles

City or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

25 hrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physicians General Hospital

25 hrs.

How long in hospital or institution?

3. (a) FULL NAME

Joseph Walter Donaldson

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 13, 1945

8. (c) If alive, give age years

8. AGE: Years 1 Months 2 Days 15 If less than one day hrs. min.

9. Birthplace Washington, D. C.

(Town, County, and state)

10. Usual occupation Infant

11. Industry or business Leonard F. Donaldson

12. Name Leonard F. Donaldson

13. Birthplace Washington, D. C.

14. Maiden name Gladys B. Jenkins

15. Birthplace Washington, D. C.

16. Informant Leonard F. Donaldson

Address Clinton, Md.

17. Burial Date thereof 8/31/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Md.

18. Funeral director W.W. Chambers Co.

Address 517-11th St. S.E.

19. 8-28 Date rec'd by registrar 1946

(Date rec'd by registrar)

Julia H. Peasey Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Prince George's

City or town

Accokeek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 28, 1946, at 5:15 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug. 28, 1946.

13. Immediate cause of death

Fulminating septicemia

DURATION

12 hrs.

Due to Accidental burns

26 hrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-27-46

Where did injury occur Accokeek, Prince George's, Md. (City or town) (County) (State)

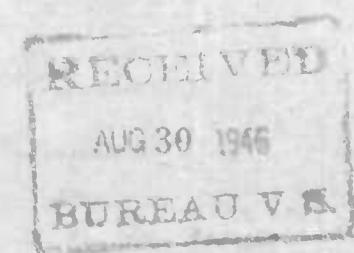
Injured at home, farm, industry, public place (where?) Home

Means of injury Fell into fire Injured at work? No

Dug. Dred. Examiner

23. SIGNATURE James F. Mackay, M.D. M. D. or other

Address La Plata, Md. Date signed 8-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

07979

Reg. Dist. No. 101

1. PLACE OF DEATH:

County CharlesCity or town Marshall Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Philip Thomas Ellery

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Ada Wolf Ellery

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Jan 18 1860

8. AGE:

86

Years

Months

Days

If less than one day

hrs. _____ min.

9. Birthplace

Grantsville Maryland

(Town, county, and state)

10. Usual occupation

Railroad man

11. Industry or business

Unknown

12. Name _____

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

16. Informant

Edith E. KennyAddress Bryant's Road Md17. (Burial, cremation, or removal) _____ Date thereof Burial Removal Aug 19, 1946 (month) (day) (year)Cemetery or crematory South SideLocation Pittsburgh, Pa18. Funeral director ChambersAddress Washington D. C.

19. Aug 18 1946 (Date read by registrar)

Mary Sutherland (Signature)

Registrar (Signature)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Marshall Hall (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 18 1943 to Aug 18 1946 and that I last saw him alive on Aug 17 1946

Immediate cause of death

Gastro-epithelial
Carcinoma

DURATION

Due to _____

Due to _____

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

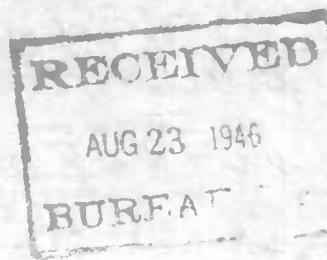
23. SIGNATURE

George C. Bicknell M.D.

M. D. or other

Address _____

Date signed Aug 18 1946



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-2

CERTIFICATE OF DEATH

07980

Reg. Dist. No. 100

1. PLACE OF DEATH:

County CharlesCity or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

3 mo.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 3 mo.

3. (a) FULL NAME

Robert M. Garner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W.

W.

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 18-1868

6. (c) If alive, give age

years

8. AGE: Years 78 Months 6 Days 5 If less than one day

hrs.

min.

9. Birthplace Pomfret Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Robert M. Garner13. Birthplace Pomfret Md.14. Maiden name Elizabeth Stewart15. Birthplace Chas Co.16. Informant Samuel BarnesAddress Indian Head Md.17. (Burial, cremation, or removal. Which?) Buried Date thereof Aug 26-1946

(month) (day) (year)

Cemetery or crematory La Plata Md.Location La Plata Md.18. Funeral director Hunt and RyanAddress Waldorf Md.19. 8-25- 1976 Julia H. Paay(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CharlesCity or town La Plata

Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-23

1946, at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-11 1941, to 8-23 1946

and that I last saw him alive on 8-23-46

19

Immediate cause of death

Cerebral Hemorrhage

DURATION

8-22-46
4-10-46
3-72-48

Due to

Arterio Sclerotic

Due to

Intoxication

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

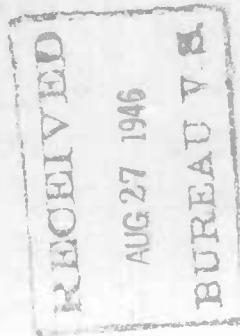
Means of injury

Injured at work?

23. SIGNATURE

Frederick M. D. or brotherLa Plata Md. Date signed 8-24-46

Address



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

07981

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County

Chesapeake
St. Plat.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Ann Theresa Green

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

Cal.

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 10, 1946

8. AGE:

Years

Months

Days

It less than one day

16

hrs.

min.

9. Birthplace

Lambkinville, Charles, Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

James Aloysius Green

13. Birthplace

Charles County, Md.

MOTHER FATHER

14. Maiden name

Hattie Theresa Clark

15. Birthplace

Charles Co., Md.

16. Informant

James Green

Address

Lambkinville, Md

17. Burial

Holy Sheet

(Burial, cremation, or removal. Which?)

Date thereof 8-28-46
(month) (day) (year)

Cemetery or crematory

Holy Sheet

Location

Towson, Md

18. Funeral director

James Green

Address

Lambkinville, Md

19. Date rec'd by registrar

8-27

19 46

Julia H. Pasey
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Charles

City or town

Lambkinville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 26, 1946, at 6:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10, 1946, to Aug 26, 1946

and that I last saw h. ~~dead~~ alive on

Aug 26, 1946

Immediate cause of death

Prematurity (7 mos gestation)

Due to

Due to Unknown - no prenatal care

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

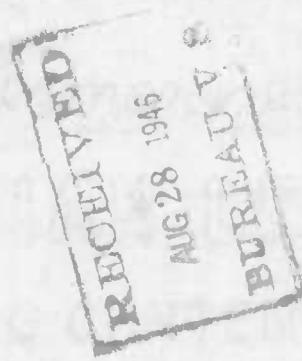
James J. MacKennaugh, M.D.

M. D. or other

Address

Dr. Plate, D.O.

Date signed 8-27-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07982

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County..... Charles

City or town..... Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Agnes Lelia Marbury.

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Robert Marbury

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years..... Sep 17 1858

8. AGE: Years..... 87 Months..... 10 Days..... 24 If less than one day..... hrs..... min.

9. Birthplace..... New Jersey - Chas Cr. Md. (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Hos. A. Miller

12. Name..... Hos. A. Miller

13. Birthplace..... New Jersey, Md.

14. Maiden name..... Emily C. Miller

15. Birthplace..... Charles Cr. Md.

16. Informant..... Mrs. Saml. Hinton

Address..... Grayton Md.

17. Burial..... Aug 12 46 (Burial, cremation, or removal? Date thereof) (month) (day) (year)

Cemetery or crematory..... Old Burkham

Location..... Trousdale

18. Funeral director..... Aunt & Ryan

Address..... Wadsworth Md.

19. Aug 11 1946 (Date record by registrar) Mary S. Mullend (Signature) Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... Charles

City or town..... Riverdale (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 10 46 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 46, to Aug 10 46, and that I last saw her alive on Aug 9 46

Immediate cause of death.....

Dysentry (Central)

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

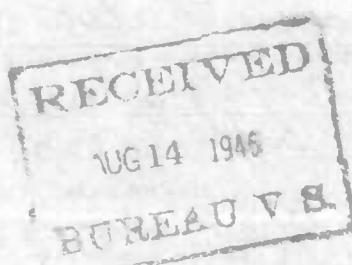
Injured at work?

23. SIGNATURE..... Geo. O. Birkley M.D.

or other

Address.....

Date signed..... Aug 11 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-6

07983

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Francis Matthews4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 19038. AGE: Years 42 Months 8 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Charles County, Md.
(Town, county, and state)10. Usual occupation Lawyer

11. Industry or business

12. Name Francis Brooke Matthews13. Birthplace Charles County, Md.14. Maiden name Anna Casine Jones15. Birthplace Calvert County, Md.16. Informant Miss Marjorie MatthewsAddress La Plata, Md.17. Burial Burial Date thereof 8-23-46
(Burial, cremation, or removal, When?) Date thereof (month) (day) (year)Cemetery or crematory St. IgnatiusLocation Bel Alton, Md.18. Funeral director Hunt & LyonAddress Valley, Md.19. Date rec'd by registrar 8-22 1946 Julia H. Raey
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CharlesCity or town La Plata
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1946 at 8⁰⁰-9⁰⁰ AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from onAug. 20, 1946 to — 1946and that I first saw him alive on Aug. 20, 1946

Immediate cause of death

Gunshot wound of brainDue to Suicide

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

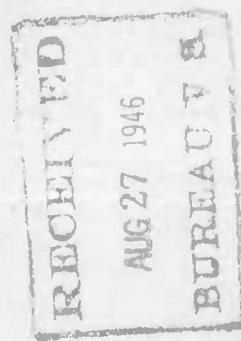
Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8-20-46Where did injury occur? La Plata, (City or town) Charles, Md. (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Revolver Injured at work? NoDuty Medical Examiner23. SIGNATURE James L. MacKenna, M.D.
M. D. or otherAddress La Plata, Md. Date signed 8-20-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

07984 106
Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frances E. Mattingly

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Married

Sarah Mattingly

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 6 1864

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Port Tobacco, Calvert Co. Md.

(Town, county, and state)

10. Usual occupation

Merchant Retired

11. Industry or business

Joe E. Mattingly

12. Name

Joe E. Mattingly

13. Birthplace

St. Marys Co. Md.

14. Maiden name

Mary C. Maddy

15. Birthplace

Calvert Co. Md.

16. Informant

Joe Mattingly

Address

Indian Head Md.

17. Burial

Date thereof: Sep 2 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Charles

Location

Glymont Md.

18. Funeral director

Hunt & Ryan

Address

Waldorf Md.

19. Date rec'd by registrar

9/2 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

Maryland County

Indian Head

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 31 1946 at 109 M
June 46 to Aug 31 1946
and that I last saw him alive on Aug 31 1946

Immediate cause of death

Cerebral Hemorrhage

Due to

Cardio-renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Geo. C. Bicknell M. D. or other
Address: Maryland Md. Date signed: Sep 140

RECEIVED

SEP 5 1946

BUREAU U S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

07985

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Edward Miles

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

w.

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Nov. 18 - 1883

6. (c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Washington D. C.

(Town, county, and state)

10. Usual occupation.....

Painter

11. Industry or business

MOTHER FATHER

12. Name.....

William Edward Miles

13. Birthplace.....

Washington D. C.

14. Maiden name.....

Adelaide Francis

15. Birthplace.....

Washington D. C.

16. Informant.....

David M. Miles

Address.....

Somersville

17. Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Congregation Emanuel

Location.....

Washington D. C.

18. Funeral director.....

William J. Miles

Address.....

8th & S. E. D. C.

19. Date rec'd by registrar.....

1946

(Date rec'd by registrar)

William J. Miles

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Somersville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 8 - 28 - 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 16, 1946, to 8 - 28 - 1946 and that I last saw him alive on 8 - 27 - 1946.

Immediate cause of death.....

Acute Heart

Due to..... Myocarditis complicating

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

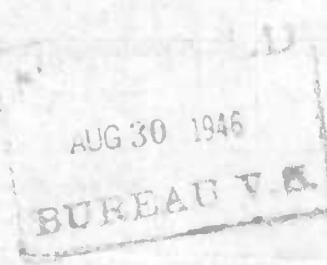
Injured at work?

23. SIGNATURE.....

J. P. Hyland

M. D. or other

Address..... Mayfield and Date signed 8 - 28 - 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

07986
165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Charles
Towson

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander Murphy

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 5 1910

6. (c) If alive, give age — years

8. AGE: Years 36 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace: New Jersey Md. (Town, county, and state)

10. Usual occupation: Labourer (Pulver factory)

11. Industry or business

12. Name: William T. Murphy.

13. Birthplace: Charles Co. Md.

14. Maiden name: Carrie V. Dodd

15. Birthplace: Charles Co. Md.

16. Informant: Mrs Carrie Murphy

Address: Towson

17. Burial: Date thereof: Aug 10 1946

(Burial, cremation, or removal. Which?) Durham

Cemetery or crematory: Location: Towson, Md.

18. Funeral director: Hunt & Ryon.

Address: Walderoff, Md.

19. (Date rec'd by registrar) Aug 9 1946 M.D. MARYL

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 8 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1946 to Aug 1946

and that I last saw him alive on Aug 8 1946

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

George C. Bicknell, M.D. or other

Address: Marlboro Rd. Date signed Aug 8 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

★ 07987
Reg. Dist. No. 100

1. PLACE OF DEATH:

County CharlesCity or town Benedict

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Benedict, Md.

How long in hospital or Institution?

3. (a) FULL NAME

Vincent Owens

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleColoredMarried

6.(b) Name of Husband or wife

Jenny OwensDe

6.(c) If alive, give age

years

7. Birth date of

deceased (mo., day, yr.)

October 28, 1892

8. AGE:

Years

Months

Days

If less than one day

53

9

19

hrs.

mo.

9. Birthplace Benedict - Charles - Maryland

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name William Owens13. Birthplace Virginia14. Maiden name Mary Craig15. Birthplace Washington, D.C.16. Informant Jenny OwensAddress Benedict, Md.17. Burial BurialDate thereof 8-19-1946

(month) (day) (year)

Cemetery or crematory St. Mary's - Bryantown, Md.

Location

18. Funeral director Elmer M. Gwader

Address

Hughesville, Md.19. 8-181946

(Date rec'd by registrar)

Julia H. Paesey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Benedict (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 194621. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 1946 to August 16 1946 and that I last saw him alive on August 8 1946

Immediate cause of death

aortic insufficiency and myocarditis

DURATION

3 yearsDue to arterio-arteritis, arterio-vascular disease

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

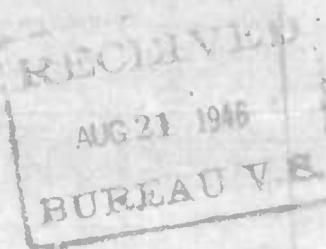
Injured at work?

23. SIGNATURE

Louis L. Garcia M.D.

M. D. or other

Address Hughesville, Md. Date signed 8-16-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

07988

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or Institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W. married

6. (b) Name of husband or wife.....

Luther A. Price

7. Birth date of
deceased (mo. day, yr.)

July 7 - 1883

6. (c) If alive, give age

72

years

8. AGE:

Years Months Days If less than one day

69

1

20

hrs.

min.

9. Birthplace.....

Bel Alton

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Meredith Jackson

12. Name.....

Meredith Jackson

13. Birthplace

Maryland

14. Maiden name.....

Mary James

15. Birthplace

Maryland

16. Informant.....

Luther A. Price

Address

Rock Point

17. Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Holy Cross

Location.....

Lafayette Md.

18. Funeral director.....

Hannan & Price

Address

Waldorf

19. 8-2-1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

1946 at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14 - 1946, to 9-1-1946
and that I last saw her alive on 9-1-1946

Immediate cause of death.....

mitral valve insufficiency

DURATION

2 months

Due to.....

Pneumonia

Due to.....

Pneumonia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed 8-5-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

07989

Reg. Dist. No. 100

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Charles

City or town..... La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 days

Hospital, Institution, or street address where death occurred:..... Physicians Medical Hospital

How long in hospital or institution?..... 8 days

3. (a) FULL NAME

Charles Lee Shymansky

4. Sex

Male White Single

6. (a) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... April 16, 1946

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

— 4 5 hrs. min.

9. Birthplace..... La Plata, Charles, Md.

(Town, county, and state)

10. Usual occupation..... infant

11. Industry or business.....

12. Name..... Andrew Shymansky,

Ches Co., Md.

13. Birthplace.....

14. Maiden name..... Margaret Spaulding,

Grayden, Md.

15. Birthplace.....

16. Informant..... Andrew Shymansky,

Cobb Island, Md.

Address.....

17. Burial..... Date thereof..... 8/22/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Shady Grove Cemetery

Location..... Laurel

18. Funeral director..... Shure & Son

Address..... Shady Grove

19. Date rec'd by registrar..... 8-21-46

19

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Charles

City or town.....

Cobb Island

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... August 20, 1946, at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 12, 1946, to Aug. 20, 1946, and that I last saw him alive on Aug. 20, 1946.

Immediate cause of death.....

Acute cardiac dilatation

Due to..... Infectious diarrhea

DURATION

8 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

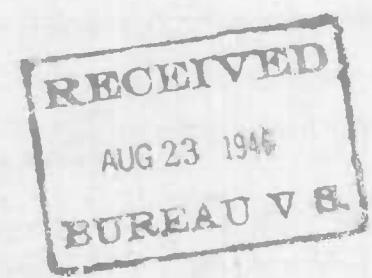
Injured at work?

23. SIGNATURE.....

James T. MacKavanagh, M.D.

M.D. or other

Address..... La Plata, Md. Date signed..... 8-20-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 430

CERTIFICATE OF DEATH

07999

Reg. Dist. No. 101

1. PLACE OF DEATH:

County

City or town

Charles
Pisgah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert M. Welch

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W

Married

6. (b) Name of husband or wife

Bessie Welch

7. Birth date of deceased (mo., day, yr.)

May 16 1872

6. (c) If alive, give age

69

years

8. AGE:

Years

Months

Days

If less than one day

74 3 15

hrs.

min.

9. Birthplace

Charles Co. Md.

(Town, county, and state)

10. Usual occupation

Pounder factory attendant

(Record)

11. Industry or business

Gas Welch

12. Name

Charles Co. Md.

13. Birthplace

Mary G. Davis

14. Maiden name

St. Mary's Co. Md

15. Birthplace

St. Mary's Co. Md

16. Informant

E. A. B. Boone

Address

Pisgah Md

17. Burial

Nazarene

(Burial, cremation, or removal which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Pisgah Md.

Location

Brent & Rose

18. Funeral director

Waldorf Md.

Address

19. Sept. 1

1946

(Date rec'd by registrar)

Mary Smith

Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Charles

City or town

Pisgah

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 31 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 to Aug 31 1946.

and that I last saw him alive on Aug 31 1946.

Immediate cause of death

Cerebral hemorrhage
Carcinoma of the rectum
with metastasis.

Due to

DURATION

Due to

DURATION

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or Other

Address

Date signed

Signature

